MassHealth Child Disability Supplement
Instructions for Completing the Supplement

You have indicated that your child has a disability. Disability standards require that the disability has lasted or is expected to last at least 12 months.

MassHealth's Disability Evaluation Service (DES) will review your child's disability. As a result it is **very important** that you **complete** the attached MassHealth Child Disability Supplement.

For your child to receive MassHealth based on his or her disability, you need to tell us:

- information about your child's medical providers (the doctors and medical facilities where your child has received treatment); and
- information about your child: educational background and daily activities.

Completing the Disability Supplement will give us this information and will help us make a decision promptly.

Please read the following instructions before beginning.

- Print, type, or write clearly and complete the supplement to the best of your ability.
- Sign and date a Medical Release Form for **each medical provider** you listed on the supplement.

After you have completed the supplement and submitted it to your MassHealth Enrollment Center, the supplement will be forwarded to the DES for review. The DES will request your child's medical records from the providers you have listed. If more information is needed, or if further tests are required, a member of the DES will contact you.

Your child's eligibility will be determined more quickly if **all items** on the supplement are completed. If you have any questions or need help with the supplement, you may contact a MassHealth eligibility worker at the number listed below. You may also call the DES Disability Supplement Hotline for help in filling out the supplement at 1-888-497-9890.

_____ (____) _____

MassHealth Eligibility Worker Telephone Number

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Contact your MassHealth Enrollment Center if you need help with this form. You may also call the DES Disability Supplement Hotline at 1-888-497-9890.

Child's name: _____ Date of birth:_____

Street Address: _____ Child's Social Security Number:_____

City: _____ State: _____ Zip:_____

Parent(s) name(s): _____

Telephone number: (home) (_____)_____

Work: (father) (_____)_____ Work: (mother) (_____)_____

If parents have different addresses and telephone numbers, please list for each parent.

_____

_____

Part I - General Information

1. Briefly describe your child's disabling condition(s) and when it first became a problem.

_____

_____

_____

2. Is this disability the result of an accident? ☐ Yes ☐ No

3 a. Does your family currently receive MassHealth? ☐ Yes ☐ No

If yes, under which program?

- ☐ Supplemental Security Income (SSI)
- ☐ Transitional Aid to Families with Dependent Children (TAFDC)
- ☐ MassHealth
- ☐ Other, please specify:

b. If recently denied or terminated from Supplemental Security Income (SSI) or MassHealth, give date, reason, and social security number (SSN).

Date: _____ Reason: _____ SSN:_____

4. Does your child receive ☐ Social Security? ☐ MassHealth?

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5. Please indicate below the agencies that are currently providing services for your child. Please indicate the contact person and the agency address.

Name of Agency	Contact Person	Address
Department of Social Services	Name: Tel.#:	
Department of Education (Chapter 766)	Name: Tel.#:	
Department of Public Health	Name: Tel.#:	
Department of Mental Health	Name: Tel.#:	
Massachusetts Commission for the Blind	Name: Tel.#:	
Other:	Name: Tel.#:	

6a. Does your child attend school? ☐ Yes ☐ No

If yes: ☐ Public ☐ Private ☐ Special Needs Children Only

Name of school: _____

Address: _____

Telephone number: _____

Name of primary teacher: _____

b. Is your child currently enrolled in a Department of Public Health Early Intervention Program?

☐ Yes ☐ No If yes, please indicate name and address of program.

Name: _____

Address: _____

c. Does your child miss school on a fairly regular basis? ☐ Yes ☐ No

If yes, how often? _____

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d. If not attending school, does your child receive home services through the school system?

☐ Yes ☐ No If yes, please explain: _____

_____

7. Is there an Individualized Education Plan (IEP) for your child? ☐ Yes ☐ No
If yes, please send a copy of the most recent IEP.

8. Is your child's developmental (functional) level age-appropriate? ☐ Yes ☐ No
If no, what is the developmental age? _____

Part II - Information About Your Doctors and Hospitals

1. Please identify below your child's primary doctor and any other doctor who may be treating your child.
Send any records you have with this supplement.

Name & Specialty	Address	Telephone	Date of Most Recent Visit
1. Primary Doctor			
2..			
3.			
4.			
5.			

Note: Please sign and date a medical release form for each provider you have listed.

2. Please identify below any hospitals, clinics, or outpatient facilities where your child has been treated in the past year.
Send any records you have with this supplement.

Name	Address	Reason for Visit	Dates
1.			
2.			
3.			
4.			
5.			

Note: Please sign and date a medical release form for each provider you have listed.

3. If a hospital visit is scheduled within the next 12 months, please note where, when, and why.

_____

_____

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Part III - Activities of Daily Living

1. **Movement:** Please note which apply to your child.

Activity	Independent	With Assistance	Is Not Able
Walk			
Crawl			
Sit Up			
Turn			

2. **Sight, Hearing, Speech:** Please note which apply to your child.

Activity	Good	Fair	Poor	None
Sight				
Hearing				
Speech				

3. **General Hygiene:** Please note which apply to your child.

Activity	Independent	With Assistance	Is Not Able
Bathing			
Dressing			

4. **Feeding:**

   a. Please indicate below how your child is able to feed and note how often and for how long.

	Feedings Per Day	Minutes Per Feeding
Oral		
Gastrostomy or Jejunostomy Tube (circle one)		
Nasogastric Tube		

   b. Please describe any special diet or formula for your child. _____

   _____

   _____

   c. Does your child receive parenteral (intravenous) nutrition? If so, please describe solutions and frequency.

   _____

   _____

5. **Toileting:** Please note which apply to your child.

	Yes	No	Other (i.e., catheter, colostomy)
Bladder Control			
Bowel Control			

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Part IV - Medical Condition

A. **Respiratory:** Does your child require any of the following respiratory aids?

1. ☐ Suction (☐ bulb or ☐ machine) Frequency: _____
2. ☐ Oxygen ☐ Humidification Number of hours/day: _____ Liter flow: _____
3. ☐ Chest physical therapy Times per day: _____

B. **Dental:**

1. How often does your child see a dentist? _____ times/year
2. Does your child have extraordinary dental problems? ☐ Yes ☐ No If yes, describe below.

_____

C. **Home Nursing Care:**

1. Does your child receive skilled nursing care at home? ☐ Yes ☐ No If yes, describe below.

_____

   a. ☐ intermittent skilled nursing visits through a home health agency

   b. ☐ private duty nursing services (continuous skilled nursing of two hours at a time or longer)
      - ☐ delivered by a home health agency
      - ☐ delivered by an independent nurse provider

2. If the answer to "1" above is yes, please note the hours and type on the weekly schedule below.

	MON	TUES	WED	THURS	FRI	SAT	SUN
Registered Nurse							
Licensed Practical Nurse							
Home Health Aide							

3. Name and telephone number of agency or individual, or both, providing the care.

_____

4. Are there additional nursing services that you feel your child would benefit from?

_____

_____

_____

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5. **Briefly describe the skilled nursing treatments or procedures required.**

_____

_____

_____

D. **Therapies:** Does your child receive therapeutic services?

☐ Yes ☐ No If yes, please note below where and what types.

Type of Therapy	Number of Visits per Week at Home	Number of Visits per Week at School	Provider Agency
Physical			
Occupational			
Speech			
Respiratory			
Other			

E. **Medications:** Please list all medications your child takes on a regular basis.

_____

_____

_____

F. **Equipment and Supplies:** Please check all items used in your child's care.

Item	Yes	No	Item	Yes	No
Ventilator			Splints		
Generator			Orthopedic Shoes		
Ambu Bag			Shoe Lifts		
Suction Machine			Tracheostomy Tubes		
Oxygen Compressor			Gastrostomy Tubes		
Oxygen Tanks			Feeding Bags/Tubing		
Apnea Monitor			I.V. Tubing		
Cardiac Monitor			Nasogastric (Feeding) Tubes		
Nebulizer			Syringes		
I.V. Pump/Pole			Formula		
Wheelchair			Intravenous Fluids		
Hospital Bed			Other		
Prone Stander					
Feeding Pump/Pole					
Walker					
Body Jacket					
Braces					

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Part V – Other Information

1. Please include any other information about your child's care that would be helpful to know in considering your request for MassHealth for your child.

   _____

   _____

   _____

2. Name and telephone number of person completing this supplement and relationship to child (for example, parent). _____

3. Names and telephone numbers of any people helping parent or guardian complete the supplement.

   _____

   _____

4. I understand that the information contained in this supplement will be reviewed by MassHealth staff and its agents for the purpose of determining my child's eligibility for medical benefits.

_____ _____

Signature of Parent or Guardian Date

Part VI - Signature and Rights

Privacy - You have a right to privacy. The information on this form is confidential. All possible precautions will be taken to ensure your privacy rights.

In making this application for myself or another person, I certify, under penalty of perjury, that the information I am submitting is correct and complete to the best of my knowledge.

If this form is being filled out by someone who has the legal authority to act on behalf of the applicant/member (such as the parent of a minor child, an eligibility representative, or a legal guardian), give us the following information:

Signature of person filling out this form: _____

Printed name of person filling out this form: _____

Authority of person filling out this form on behalf of the applicant/member: _____

The DES may send copies of notices to the eligibility representative. This section does **not** authorize release of medical records.